

**Oklahoma Health Insurance High Risk Pool
Summary of Benefits
Original Plan - Effective 04/01/2012**



**Calendar Year Deductible Options:
\$500/\$1,000/\$1,500/\$2,000/\$5,000/\$7,500**

BENEFIT HIGHLIGHTS

**BlueChoice PPO
Network**

This provides only highlights of the plan. After enrollment, members will receive a Certificate of Benefits that more fully describes the terms of coverage.

Program Basics		Plan Benefits	
Lifetime Benefit Maximum			
Per individual		\$1,000,000	
Individual Coverage Deductible			
Per individual		\$500/\$1,000/\$1,500/\$2,000/\$5,000/\$7,500	
Individual Coverage Out-of-Pocket Limit			
<p>The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit:</p> <ul style="list-style-type: none"> • Prescription drug copayments • Charges for services that have a separate benefit maximum • Calendar year deductible • Precertification non-compliance penalties 		<ul style="list-style-type: none"> • \$2,000 per family member, plus deductible, for Blue Choice network providers • \$4,000 per family member for out-of-network providers, plus deductible, and charges above Blue Choice network allowable charge* <p>Once you have met your Out-of-Pocket limit the Plan will pay 100% of the allowable amount.</p>	
Co-Insurance			
Blue Choice Network		Plan pays:	
		• 80% of the BlueChoice allowable amount	
Out-of-network*		• 60% of the BlueChoice allowable amount*	
Physician Services		Plan Benefits	
Physician Office Visits			
Surgeries, therapies, and certain diagnostic procedures performed in a physician's office will be subject to the deductible and/or coinsurance.		Annual deductible and coinsurance apply	
Medical / Surgical Services			
Coverage for surgical procedures, inpatient and outpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.		Annual deductible and coinsurance apply.	
Hospital Services		Plan Benefits	
Coverage includes medically necessary services received in a hospital, skilled nursing facility, coordinated home care and hospice. Room allowances based on the hospital's most common semi-private room rates.		Annual deductible and coinsurance apply.	
Prescription Drug Card (Retail & Mail-At-Retail Service) - Administered by MaxCare Prescription Benefit Services			
		1-30 day supply	31-90 day supply
Generic:		\$15 Copayment	\$45 Copayment
Preferred Brand Name:		\$40 Copayment	\$120 Copayment
Non-Preferred Brand Name:		\$70 Copayment or 30% Whichever is greater	\$210 Copayment or 30% Whichever is greater
Specialty/Biotech:		\$100 Copayment	Not available in 31+ days

*Amount above Blue Choice allowable fee will be subject to balance billing when out-of-network services are rendered.

To Locate a Participating Medical Provider: Visit our Web site at www.bcbsok.com/ohrp and use our Provider Finder® tool.
To contact MaxCare: Visit their Web site at www.maxcarerx.com or call 1-800-259-7765.